

**IRO NOTICE OF DECISION – WC**

**July 26, 2007**

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**DATE OF REVIEW:** 07-13-2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Standard wheelchair

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Certified by the American Board of Neurological Surgery  
General Certificate in Neurological Surgery

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/ Overturn
		Prospective	724.4	E1399	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notification of Determination (06-19-07 & 07-06-07)

Follow Up Exam – Lumbar Spine (04-03-07 & 05-17-07)

Physician Visit Notes (11-02-06)

MRI lumbar Spine (05-11-07)

Initial Examination Physical Therapy (04-16-07)

Operative Report (05-19-06 & 12-20-06)

Surgical Pathology Report (reported 05-23-06)

Information submitted by claimant: letter dated 07/02/07, physician report of 06/20/07 and prescription, physician report of 06-26-07 and prescription

**PATIENT CLINICAL HISTORY:**

This claimant is status post two (2) lumbar surgeries: hemilaminotomy L4-5, L5-S1 bilaterally on 05-19-06, and bilateral L4-5 hemilaminectomy medical facetectomy and foraminotomy with discectomy and excision scar tissue. The claimant noted he was in physical therapy postoperatively and had recurrent left leg and low back pain. Repeat MRI showed recurrent herniation on the left at L4-5. The possibility of discitis has been considered and rule out.

The claimant claims in letter of 07-10-07 that he cannot walk 10 feet without need to sit down presumably due to pain. The request for standard wheelchair was non-certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Criteria used in analysis: ODG Guideline do not address wheelchair use under procedure summary for ICD-9 724.4

The Reviewer using Blue Cross of California, Clinical UM Guideline # CG-DME-34, current effective date: 07/02/07, noted there is no indication that the claimant: 1) lacks functional mobility to safely and efficiently move about to perform activities of daily living in home setting; 2) or that he would be confined to chair or bed without wheelchair; and 3) that other assistive devices, e.g., canes, walkers are insufficient or unsafe to completely meet functional needs.

The Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

